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BY

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OF NEW YORK.

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By W. H. HAYNES, M.D.,
Of New York.

On the night of September 5, 1882, I was summoned to see the fourth child of Mrs. A., who had been born on the afternoon of the 3d, in consequence of its not having had a stool since birth. Upon arriving at the house, I found a male child apparently not suffering, and without any external marks of abnormality. Domestic cathartics had been administered without success, and the midwife, on attempting to give a warm soap-water enema, found that the nozzle of the syringe could be introduced within the anus only for a short distance, and the fluid injected immediately returned without causing a fecal evacuation. Proceeding to examine, I found I could only introduce the tip of my little finger within a naturally formed anus for about half an inch, into a cul-de-sac to which there was but one opening—that of entrance. Nothing distinguishable could be made out beyond the limiting membrane in the abdominal cavity. In other respects the child was perfectly natural; nursed, did not vomit, slept, and urinated. The condition of affairs was explained to the parents, who were warned against using any evacuant measures, but, if necessary, to administer small doses of paregoric p. r. n.

The next morning the child was seen by Prof. Van Buren, who gave the opinion that the best procedure in this case was left inguinal colotomy. That night the child was restless, cried, and vomited a little curdled milk.

On the 7th of September, just before noon, in my office, assisted by Drs. Hathaway, Church, and Busche, the child being four days old, was chloroformed so that a thorough examination could be made previous to operating. It had urinated just before coming to my house. The abdomen was noticed to be more distended and tympanitic on the left side, but no tumour could be detected. The anal cul-de-sac was examined by finger, probe, and by sight, through an ear speculum, without finding any internal orifice. It was thought by some of the gentlemen present, that a doughy mass was distinguishable upwards and to the left side of the pelvic cavity. A trocar was carefully thrust in this direction, through dense unyielding tissue, as far as was thought justifiable, but nothing came through the canula. I then proceeded to open the colon in the left

groin. An incision one-and-a-half inch long was made just above and parallel to Poupart's ligament. The different layers of adipose and muscular tissue and peritoneum were laid open on a director. One vessel required a ligature; I then introduced my finger into the abdominal cavity, traced up the colon (which was empty) from below, and, with a pair of thumb forceps, drew out the part nearest the wound. It was held fast by two ligatures, drawn out of the wound, an opening made giving exit to some gas and meconium, and the edges of the wound in the intestine united by a number of sutures to the wound in the abdominal wall. The parts were cleansed with a warm, weak solution of carbolic acid and water, and the same was used throughout the operation for hands, instruments, and sponging. A piece of lint spread with vaseline was placed over the wound, and a diaper over that completed the dressing. The time occupied in the examination and operation was a little over an hour. When I saw the child at its home in the evening, it had considerable fever, rapid pulse, and would not nurse. Two large stools had escaped from the upper opening of the gut in the wound.

8th, 10 A. M. Temperature 99°; pulse 110. Has had another stool since last visit; nursed a little; slept though very restless. Abdomen swollen, particularly the parts around the wound, which is also very much congested and tender. Has passed no urine. Ordered a mixture of aconite, paregoric, and nitre. In the evening there was less fever, pulse 120; slept all day; had two stools; urinated, and nursed without vomiting.

9th, A. M. No jaundice; has slight fever; is bright and lively; slept well; nursed without vomiting; had stools and urinated. Abdomen softer, parts about wound less swollen and congested. Applied a salve of iodoform, bals. Peru, and vaseline to the wound, first cleansing it, after each stool. P. M. No fever; pulse 110; nursing, sleeping, etc., the same as any baby in health.

15th. Improvement continues. The ligature from off the vessel came away yesterday, and some of the sutures have been removed.

26th. The baby has been suffering from indigestion, giving rise to diarrhœa, crying, and straining, and causing prolapse of the gut at the upper end of the wound, and oozing of some blood. The sutures have all been removed, and the wound is entirely united.

30th. Under chloroform, and after urination, a sound was passed into the lower opening of the gut in the wound downwards and backwards, till its tip could be readily felt by the finger within the anus, seemingly only separated by a thin partition of tissue. A crucial incision was made, allowing the end of the sound to emerge at the anus, and the opening dilated with a small, soft urethral bougie and open forceps. A coil of lamp wick was passed through the natural and artificial anal openings to serve as a guide for future measures.

October 12. A bougie, No. 24 F., can be passed through the rectum and into the abdominal opening. Feces pass at both natural and artificial openings.

31st. The child's general condition is very good. A metal pad and rubber bandage closes the artificial opening, restraining the passage of feces and prolapse of the intestine, so that all stools occur at the natural opening, which also allows of a free passage through the rectum of a large sized bougie. Dilatation was continued till I could pass the first phalanx of my index finger through the new rectal canal. During this time the abdominal opening had contracted over one half its original extent. I

attempted to close it by paring the edges and uniting them with silver wire, but the sutures tore out, and no union was obtained.

On *December* 10, 1882, the case was dismissed. All stools passed by the natural opening. The abdominal fistule was very small and covered by a metal pad and bandage. The mother was instructed to pass her finger through the rectum daily.

August 2, 1883. The child is now eleven months old. Its skeleton has grown but its body is emaciated. Has the four first incisor teeth, and getting the others. The parents have neglected to keep up dilatation of the rectum, so that now there is only a fistulous passage; all stools passing through the abdominal opening. This was the last time I saw the child. I afterwards heard that some time after I saw it the child was taken with convulsions ascribed to teething and died.

"Embryologists tell us that, during the early development of the fœtus in the process of budding from the hypoblast, by means of which the various abdominal organs are envolved, the bud that branches towards the anus to form the rectum is sometimes arrested in its progress, so that it fails to meet the bud from the epiblast which forms the anus, and the result is an interval in which the rectum is wanting, either a mere partition, or bulkhead or a distinct space intervening, varying from half an inch in length, usually occupied by a fibrous cord."[1]

The above description succinctly states the nature of the deformity in that variety of imperforate rectum where the anal opening is properly formed, and in which class our case would be placed.

As showing the effect of hereditary influence in these cases which is similar to that seen in all the other congenital deformities, I cite the following remarkable instance reported by Dr. Githens to the Obstetrical Society of Philadelphia:[2] where the same parents had two children so deformed, and the mother's maternal aunt had had five out of seven children deformed in like manner. All these seven children perished, two after operations for their relief. What a stimulus this striking record of mortality should be, causing us to strenuously increase our efforts to seek out the best and safest methods of achieving success in these unfortunate cases.

The symptoms presented in our case were simply those of the non-performance of an important function, which is the only evidence ever presented in the early stages of this malady, and should cause us to make diligent examination for this deformity. This, I am sorry to say, is often neglected till grave constitutional symptoms present themselves, which make an unfavourable prognosis a foregone conclusion. This latter train of symptoms often sets in early (after the first few days) on account of the tender nature of these young children, whereas an early operation is half the cure. The diagnosis of this condition is so easy that it can be made by non-professional persons, as happened in this case, where the midwife, whose intelligence I must say is above the general average of midwives,

[1] Van Buren on the Rectum, revised edition, 1881, page 367.

[2] Medical News, vol. xli. page 552.

had correctly made out the condition. The prognosis is undoubtedly fatal unless relieved by art or nature. Nature sometimes relieves these patients in one of two ways: either by ejecting the excrement matter through vomiting, or by the formation of a fistulous opening before birth, generally in connection with one or the other of the adjacent canals. Noteworthy examples of these two modes of nature's cures are the following: "Mr. Cripps reported to the Pathological Society of London[1] the case of a child thirty days old with imperforate rectum, who was apparently quite well, food being well taken and fecal matter vomited three or four times a day;" and Curling mentions a case alive after twelve weeks of such existence.[2] Dr. Fenwick of Montreal, at the last meeting of the Canada Medical Association,[3] narrated the case of a man who all his life had defecated through a fistulous opening which was situated at the root of the penis, and which communicated with the rectal tube. Other cases of this latter nature could be given, particularly as occurring in female children.

The different plans which art has devised for the treatment of the various forms of rectal deformity found at birth may be classified under three general heads:—

1. Perineal puncture and dissection, including Verneuil's operation of extirpation of the coccyx.
2. Lumbar colotomy.
3. Inguinal colotomy.

Their different uses are so well discussed in the later works on surgery, and particularly in the latest monographs on this special branch, that I will not stop to discuss this part of the subject, simply stating that the treatment pursued in this case will be found to be in accordance with the rules laid down by these authorities, and with the eminent counsel we had to guide us before proceeding to operate, and that the result will add its testimony to the weight of opinion in favour of the operation performed. I found it to be simple, to be easy of performance, and to give immediate access to all the parts concerned.

The result is the more surprising when the bad social and hygienic surroundings of the child are considered. Its parents were of the lowest order of society, very poor, living in such a wretched habitation as to be unfit for the performance of the operation, and they were constantly hoping death would release them of their burdensome charge. Only the commonest antiseptic precautions were observed without the spray. One circumstance that materially aided in the obtaining of so favourable a result was the early performance of the operation, before the usual evidences of debility from distress and suffering had shown themselves. This record adds another successful case to the short list given in the American

[1] Lancet, May 15, 1880.
[2] Curling on the Rectum, edition of 1876, page 224.
[3] Medical News, vol. xliii. page 303.

edition of Holmes's *System of Surgery*, 1882, vol. iii. p. 851, where is reported the only other successful case since 1859 by Dr. Pooley, who operated for imperforate rectum with a vaginal fecal fistula.

One procedure in the treatment of this case I do not find discussed anywhere in detail, namely, that of opening up a passage at the natural site for the canal, either simultaneously or subsequent to the operation opening into the gut. Where the two operations are to be performed at the same time, the first or inguinal opening is in the nature of an exploratory operation, and should be made small so as to admit of immediate closure, and return to the peritoneal cavity after a passage is secured at the natural site. If this latter is not secured, then the opening could be enlarged and made to serve the purpose of an artificial anus in the abdominal wall. The advisability of this procedure, however, is at present very doubtful, which only the experience of a number of operators can determine. Of the few cases so far undertaken in this manner that I can find recorded, my own case is the only one that survived the second operation. The other cases so treated were two by Owen, the latest and best authority on this subject, both of which died after successfully surviving left inguinal colotomy.[1] He graphically sums up his experience in these cases as follows :—

"Granted, then, that an artificial anus must be performed, let the groin be opened, and let no sharp instrument be at any time blindly thrust upward into the interior of the pelvis through the carefully performed dissection in the perineum. Let there be no delay, no waiting for symptoms, which in tender babes are but the beginning of the end; no expectation of a manifest bulging of the upper piece of bowel. It may never become filled at all, for, as in one of my cases, the meconium may grow firm and scanty from an absorption of the watery part; and should the operation be a success as regards saving life, at least let there be something more than hesitation at the subsequent proposal to attempt the construction of another artificial anus at the most convenient site."

My own single experience, though successful, does not lead me to advise this procedure, for the object of it will, during the early years of its life, be dependent on the exceedingly diligent and constant attentions of others whose affections and services, though the closest, are not to be depended on, as was demonstrated in my case. If the second operation is subsequent to the first, he will have a double annoyance, or be under the necessity of having a third operation performed for the closure of the opening first made, which is not unattended by danger to life or by doubts as to the result, and perhaps be under the necessity of having it reopened from neglect in the proper after-treatment of the new canal in the natural site. Whereas, if one is satisfied with having saved life in a manner which, as numerous cases testify, is not unenjoyable or full of discomfort, as used to be maintained, all dangerous risks of subsequent operations are avoided, there will be no more dependence on other's services than is natural, and many sources of distress that natural flesh is heir to will be obviated.

[1] Harvelan Lectures, 1879.

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